

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, who should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 & 2 should be filed with the registrar.

10196 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

10183  
92

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hacks Point</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		d. STREET ADDRESS <b>X</b>	
3. NAME OF DECEASED (Type or print) First <b>Cecil</b> Middle <b>Barton</b> Last <b>Barton</b>		4. DATE OF DEATH Month <b>October</b> Day <b>19</b> Year <b>19 56</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/2/98</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>? Daggott</b>		14. MOTHER'S MAIDEN NAME <b>A Della Adylotte Queen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>I</b>		16. SOCIAL SECURITY NO. <b>186-07-9012</b>	
17. INFORMANT <b>3589 Indian Lane Philadelphia, Pa.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic nephrosis</b> (c) <b>Chronic Glomerulonephritis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe nephrosis (massive albuminuria)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1956</b> , to <b>Oct 19 1956</b> , that I last saw the deceased alive on <b>Oct 19 1956</b> , and that death occurred at <b>1:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wallace Obenshain</b> M.D.		ADDRESS (Street, city or town, state) <b>Cecilton, Md.</b> DATE SIGNED <b>Oct 19, 1956</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Wallace Obenshain, Cecilton, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>10-23-1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>West Laura Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Philadelphia, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry Hoppin Elkton, Md</b>		24g. REC'D BY REGISTRAR <b>10/22/56</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>IR Frazer</b>			

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Date of Registration		12. Office of Registrar	
13. Name of Informant		14. Relationship		15. Signature of Informant	
16. Name of Informant		17. Relationship		18. Signature of Informant	
19. Name of Informant		20. Relationship		21. Signature of Informant	
22. Name of Informant		23. Relationship		24. Signature of Informant	
25. Name of Informant		26. Relationship		27. Signature of Informant	
28. Name of Informant		29. Relationship		30. Signature of Informant	
31. Name of Informant		32. Relationship		33. Signature of Informant	
34. Name of Informant		35. Relationship		36. Signature of Informant	
37. Name of Informant		38. Relationship		39. Signature of Informant	
40. Name of Informant		41. Relationship		42. Signature of Informant	
43. Name of Informant		44. Relationship		45. Signature of Informant	
46. Name of Informant		47. Relationship		48. Signature of Informant	
49. Name of Informant		50. Relationship		51. Signature of Informant	
52. Name of Informant		53. Relationship		54. Signature of Informant	
55. Name of Informant		56. Relationship		57. Signature of Informant	
58. Name of Informant		59. Relationship		60. Signature of Informant	
61. Name of Informant		62. Relationship		63. Signature of Informant	
64. Name of Informant		65. Relationship		66. Signature of Informant	
67. Name of Informant		68. Relationship		69. Signature of Informant	
70. Name of Informant		71. Relationship		72. Signature of Informant	
73. Name of Informant		74. Relationship		75. Signature of Informant	
76. Name of Informant		77. Relationship		78. Signature of Informant	
79. Name of Informant		80. Relationship		81. Signature of Informant	
82. Name of Informant		83. Relationship		84. Signature of Informant	
85. Name of Informant		86. Relationship		87. Signature of Informant	
88. Name of Informant		89. Relationship		90. Signature of Informant	
91. Name of Informant		92. Relationship		93. Signature of Informant	
94. Name of Informant		95. Relationship		96. Signature of Informant	
97. Name of Informant		98. Relationship		99. Signature of Informant	
100. Name of Informant		101. Relationship		102. Signature of Informant	

RECEIVED  
OCT 25 1956  
BUREAU V. 3.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10184

10210

## CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Warwick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Warwick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Main Street</u>		STREET ADDRESS (If rural give location) <u>Main Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Lillian</u>	(Middle) <u>May</u>	(Last) <u>Bowman</u>
4. DATE OF DEATH	(Month) <u>Oct</u>	(Day) <u>16</u>	(Year) <u>1956</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug 29, 1889</u>
9. AGE last birthday <u>67</u> yrs.		If under 1 year: Months <u>0</u> Days <u>16</u> Hours <u>15</u> Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Sassafras, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Pope</u>		14. MOTHER'S MAIDEN NAME <u>Rosanna Hoover</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Chas Bowman, son</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

191X Immediate cause (a) Cancer of neck with erosion of vital structures

Antecedent cause(s) (b) Squamous cell Ca probably

(c)

INTERVAL BETWEEN ONSET AND DEATH 2 years

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1956 to 16 Oct., 1956, that I last saw the deceased alive on 16 Oct., 1956, and that death occurred at 2:45 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Oct 20, 1956</u>	<u>Townsend cemetery</u>	<u>Townsend Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Oct 18-1956</u>	<u>Wm Ralph H. Bee</u>	<u>G. Lester Daniels</u>	<u>Middleton</u>

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OCT 23 1956

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10185

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

10211

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 13yrs.7 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 3939 Greenmount Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle G. Last BRENNAN				4. DATE OF DEATH Month October Day 8 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-12-93		9. AGE (In years lost birthday) 62 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Brennan				14. MOTHER'S MAIDEN NAME Alice Nungent			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW I		16. SOCIAL SECURITY NO. <del>Unknown</del> None		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Bronchopneumonia, bilateral, unresolved DUE TO (b) Coronary heart disease severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Arteriosclerosis, general, severe DUE TO (c) Arteriosclerosis, general, severe						INTERVAL BETWEEN ONSET AND DEATH 5-7 days unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 10, 1943, to October 8, 1956, and that death occurred at 12:55 a.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. V.A. Hospital, Perry Point, Md.		ADDRESS (Street, city or town, state)		DATE SIGNED 10-8-56	
PHYSICIAN'S NAME (Type) <i>[Signature]</i>		E. P. BRANNON, M.D. Manager		Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-10-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran, 3000 E. Baltimore St., Baltimore, Md.				24a. REC'D BY REGISTRAR DATE 10 1956		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		SEX	
PLACE OF BIRTH		CITY		STATE	
OCCUPATION		EDUCATION		RELIGION	
MANNER OF DEATH		CAUSE OF DEATH		PERIOD OF ILLNESS	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	

BUREAU V. S.

OCT. 10 1956

RECEIVED



92

MEDICAL CERTIFICATION

VS. A15ME(5)  
5M 9/55





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10187 92  
Reg. Dist. No.

10198

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>82 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b> <b>21</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>204 North Street</b>				d. STREET ADDRESS <b>8 204 North Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bertha</b> Middle <b>Brown</b> Last <b>Brown</b>				4. DATE OF DEATH Month <b>October</b> Day <b>27</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14 1874</b>		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George A. Brown</b>				14. MOTHER'S MAIDEN NAME <b>Hannah Elizabeth Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Elizabeth Brown</b> Address <b>204 North Street, Elkton Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial failure</b> <b>444x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Essential Hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>Oct 1-1956</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
					20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>October 1, 1956</b> to <b>Oct 27, 1956</b> , that I last saw the deceased alive on <b>Oct 26, 1956</b> , and that death occurred at <b>5 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Milford H. Sprecher</b> M.D.				ADDRESS (Street, city or town, state) <b>135 W. Main St., Elkton, Md.</b> DATE SIGNED <b>Oct. 29-56</b>			
PHYSICIAN'S NAME (Type) <b>Milford H. Sprecher, M. D.</b>				<b>135 W. Main St., Elkton, Md. 10/26</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-30-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Elkton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elkton, Cecil County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b> ADDRESS <b>North East, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>10/30/56</b>		24b. REGISTRAR'S SIGNATURE <b>JR. Frazier</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES E. BROWN		OCT 31 1956		BALTIMORE, MD	
AGE		SEX		RACE	
65		M		W	
MARRIED		OCCUPATION		CAUSE OF DEATH	
Y		LABORER		HEART DISEASE	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION	
OCT 10 1891		BALTIMORE, MD		HIGH SCHOOL	
MOTHER'S NAME		FATHER'S NAME		MANNER OF DEATH	
MARY E. BROWN		JAMES E. BROWN		NATURAL	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
OCT 31 1956		BALTIMORE, MD		HEART DISEASE	
MARRIED		OCCUPATION		CAUSE OF DEATH	
Y		LABORER		HEART DISEASE	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION	
OCT 10 1891		BALTIMORE, MD		HIGH SCHOOL	
MOTHER'S NAME		FATHER'S NAME		MANNER OF DEATH	
MARY E. BROWN		JAMES E. BROWN		NATURAL	

BUREAU V. 3

OCT 31 1956

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, pages 1 and 2, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10199 CERTIFICATE OF DEATH

10188

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>1 year</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Devine Haven Nursing Home, Main St.</b>				d. STREET ADDRESS <b>R. D. Elkton</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>L.</b> Last <b>BUCHANAN</b>				4. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 23, 1865</b>	
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months <b>91</b> Days <b>91</b> Hours <b>91</b> Min. <b>91</b>		IF UNDER 24 HRS. Months <b>91</b> Days <b>91</b> Hours <b>91</b> Min. <b>91</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired -Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>John Null</b>				14. MOTHER'S MAIDEN NAME (last) <b>Perry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Norman Buchanan, Newark, Delaware</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO <b>2-4 years</b> (c) <b>Generalized Arteriosclerosis</b> DUE TO <b>10 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 days</b> INTERVAL BETWEEN ONSET AND DEATH <b>2-4 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>8:18</b> , 19 <b>55</b> , to <b>10:5</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10:5</b> , 19 <b>56</b> , and that death occurred at <b>6:13 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Elkton, Md.</b> DATE SIGNED <b>10.6.56</b>							
ACTUAL SIGNATURE <b>Peter Stavrakis</b> M.D. <b>Elkton, Md.</b>							
PHYSICIAN'S NAME (Type) <b>Peter Stavrakis, M. D.</b> <b>154 West Main St., Elkton, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 8, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cecil County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph E. Hickey</b> ADDRESS <b>103 Stockton St. Elkton, Md.</b>				24a. REC'D BY REGISTRAR <b>10/6/56</b>		24b. REGISTRAR'S SIGNATURE <b>FR Trauger</b>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
JAMES H. HARRIS		Male		45		1910		Maryland		Baltimore		Heart Disease		1956		10:00 AM		Home		J. H. Harris		J. H. Harris	
Occupation		Marital Status		Education		Religion		Previous Illnesses		Last Medical Examination		Manner of Death		Burial or Disposition		Funeral Home		Burial Place		Date of Burial		Signature of Minister	
Teacher		Married		High School		Catholic		Hypertension		1955		Natural		Buried		St. Mary's		St. Mary's		1956		J. H. Harris	

BUREAU A

OCT 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10189

10212

## CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Morgan Nursing Home</b>		c. LENGTH OF STAY IN 1b <b>1 week</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Chesapeake City</b>			d. STREET ADDRESS <b>209 Howard St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Elizabeth Louise Buckworth</b>			4. DATE OF DEATH <b>October 22 1956</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>Wh.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 29, 1876</b>		9. AGE (In years last birthday) <b>85</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Wife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>James Henry Buckwith</b>			14. MOTHER'S MAIDEN NAME <b>Annie Quinley</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Ester Rambo, Hermitage Drive, Elkton, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia of Heart</b> <b>334x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Chesapeake City, Md.</b>		20g. (County) <b>Cecil</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Oct 18</b> , 19 <b>56</b> , to <b>Oct 23</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Oct 23</b> , 19 <b>56</b> , and that death occurred at <b>8:00 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chesapeake City, Md.</b> DATE SIGNED <b>10/15/56</b>					
ACTUAL SIGNATURE <b>Henry V. Davis M.D.</b>		M.D. <b>Chesapeake City, Md.</b>			
PHYSICIAN'S NAME (Type) <b>HENRY V. DAVIS M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 25, 56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethel cemetery</b>	
22d. LOCATION (City, town, or county) <b>R. D. Chesapeake City, Md.</b>		(State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Henry Poppin</b>		ADDRESS <b>259 E. Main St. (W.A.L.)</b>		24a. REC'D BY REGISTRAR <b>10/27/56</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Poppin</b>					



0001 25 200

BUREAU V. S.

OCT 30 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filled with burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10200

## CERTIFICATE OF DEATH

Reg. Dist. No.

10190  
92

1. PLACE OF DEATH o. COUNTY <b>CECIL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKTON</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>UNION HOSPITAL</b>		d. STREET ADDRESS <b>Elkton</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>(unnamed) BURGESS</b>		4. DATE OF DEATH Month Day Year <b>OCTOBER 16 19 56</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 16, 1956</b>
9. AGE (In years lost birthday) yrs. <b>2</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>770.0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>770.0</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>770.0</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SILAS BURGESS Jr.</b>		14. MOTHER'S MAIDEN NAME <b>MARY KATHERINE CALDERIS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>SILAS BURGESS Jr. ELKTON, Md.</b>	
17. INFORMANT <b>SILAS BURGESS Jr. ELKTON, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemolytic Anemia, familial</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Clifton R. Brooks</b> <b>Newark, Delaware</b> <b>10/17/56</b>			
ACTUAL SIGNATURE <b>Clifton R. Brooks</b> M.D. <b>Newark, Delaware</b> <b>10/17/56</b>			
PHYSICIAN'S NAME (Type) <b>Clifton R. Brooks</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>OCT. 18, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GILPIN MANOR PARK</b>		22d. LOCATION (City, town, or county) (State) <b>ELKTON Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elmyr J. J. J.</b>		24a. REC'D BY REGISTRAR DATE <b>10/20/56</b>	
24b. REGISTRAR'S SIGNATURE <b>FR J. J.</b>		24c. REGISTRAR'S SIGNATURE <b>FR J. J.</b>	

2065314XV 4

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
MARRIAGE		PLACE OF DEATH	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF BURIAL	
AGE		SEX	
DATE OF BIRTH		PLACE OF BIRTH	
EDUCATION		RELIGION	
MILITARY SERVICE		PREVIOUS ILLNESS	
SMOKING HABIT		ALCOHOLIC HABIT	
DIET		EXERCISE	
FAMILY HISTORY		SOCIAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
PATHOLOGICAL FINDINGS		MEDICAL OPINION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	

BUREAU V. S.

OCT 22 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 1810191

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

90

10213

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Chester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Earlville R.D.</u>		c. LENGTH OF STAY IN 1b <u>just this day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>		75 x 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>White Crystal Beach</u>				d. STREET ADDRESS <u>538 E. 15th St. xC</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>R. Canavan</u> Last <u>V</u>				4. DATE OF DEATH Month <u>10</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-24-1890</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General work</u>		11. BIRTHPLACE (State or foreign country) <u>Chester, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Canavan</u>				14. MOTHER'S MAIDEN NAME <u>Florence Long</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>185-28-9744</u>		17. INFORMANT <u>Marion Canavan</u> Address <u>538 E 15th St. Chester, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-12-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>10/11/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Go Chester, Penna</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Pappan</u> <u>Elkton, Md.</u>				24a. REC'D BY REGISTRAR <u>10/13/56</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. Ralph</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. The funeral director should be given a copy of this certificate for burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
OCT 16 1956  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE

10201

## CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH—BALTIMORE, 18

10192

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton,			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George B. Conrey			4. DATE OF DEATH October 13 1956				
5. SEX M	6. COLOR OR RACE Wh.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1876		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tin Smith			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John Conrey				14. MOTHER'S MAIDEN NAME Mary No Information on last Name			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-14-3483		17. INFORMANT Mary Lousla Conrey, Chesapeake City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1954, to October 13, 1956, that I last saw the deceased alive on Dec 12, 1956, and that death occurred at 2:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Chesapeake City, Md 10/13/56 ACTUAL SIGNATURE HENRY K. DAVIS M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-16-1956		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) R. D. Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. Henry Piffin				ADDRESS Elkton Md.		24a. REC'D BY REGISTRAR DATE 10/15/56	
				24b. REGISTRAR'S SIGNATURE J. R. Frager			

# CERTIFICATE OF DEATH

1. Name of deceased JAMES EARL RAY		2. Date of birth JAN 5 1928		3. Sex M		4. Race W		5. Marital status M		6. Date of death JUN 4 1968		7. Place of death MEMPHIS, TENN		8. Cause of death SHOOTING		9. Manner of death HOMICIDE		10. Signature of physician JAMES EARL RAY		11. Signature of medical examiner JAMES EARL RAY		12. Signature of coroner JAMES EARL RAY		13. Signature of registrar JAMES EARL RAY		14. Signature of funeral director JAMES EARL RAY		15. Signature of undertaker JAMES EARL RAY		16. Signature of cemetery JAMES EARL RAY		17. Signature of burial place JAMES EARL RAY		18. Signature of interment JAMES EARL RAY		19. Signature of cremation JAMES EARL RAY		20. Signature of other JAMES EARL RAY	
21. Date of burial JUN 10 1968		22. Place of burial MEMPHIS, TENN		23. Cause of death SHOOTING		24. Manner of death HOMICIDE		25. Signature of physician JAMES EARL RAY		26. Signature of medical examiner JAMES EARL RAY		27. Signature of coroner JAMES EARL RAY		28. Signature of registrar JAMES EARL RAY		29. Signature of funeral director JAMES EARL RAY		30. Signature of undertaker JAMES EARL RAY		31. Signature of cemetery JAMES EARL RAY		32. Signature of burial place JAMES EARL RAY		33. Signature of interment JAMES EARL RAY		34. Signature of cremation JAMES EARL RAY		35. Signature of other JAMES EARL RAY											

BUREAU V. 2

OCT 18 1966

RECEIVED



VS. A15ME(5)  
5M 9/55

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN lb <b>8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charlestown</b>		d. STREET ADDRESS <b>Union Hospital</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Clifford</b>		First <b>Cottle</b>		Middle <b>Cottle</b>		Last <b>10</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-9-1890</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>1</b>		IF UNDER 24 HRS. Days <b>1</b>		Year <b>19 56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lumberman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Saw Mill</b>		11. BIRTHPLACE (State or foreign country) <b>Harford Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edwin Cottle</b>		14. MOTHER'S MAIDEN NAME <b>Annie E. McAbie</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-16-4844</b>	
17. INFORMANT <b>Lillian C. Wilson, Charlestown, Md.</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture right Parietal bone with laceration of</b> <b>904.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>brain tissue. Terminal Pneumonia</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was found in yard with injuries not known how.</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>9-23-56</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) (County) (State) <b>Charlestown Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R. C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R. C. Dodson</b>						DATE SIGNED <b>10-1-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-4-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Coatesbury Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Abingdon, Harford Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. A. Patterson</b>		ADDRESS <b>Perthville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>10/3/56</b>		24b. REGISTRAR'S SIGNATURE <b>J. R. Frazer</b>	

RECEIVED

OCT 5 1956

BUREAU V. 2

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF EXAMINER: [illegible]  
DATE OF SIGNATURE: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, or 3 days after death, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10214

## CERTIFICATE OF DEATH

Reg. Dist. No. 96 10194

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>31 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. STREET ADDRESS <b>921 S. Ellwood Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>(NMI)</b> Last <b>DEMNOWICZ</b>				4. DATE OF DEATH Month <b>October</b> Day <b>16</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 1 1891</b>		9. AGE (In years last birthday) <b>65</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Boats</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <input checked="" type="checkbox"/> <b>WW I</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital records, VAH, Perry Point, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002X</b> <b>Tuberculosis, pulmonary, arrested</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. ft. <b>VA</b> 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 17</b> , 19 <b>25</b> , to <b>October 16</b> , 19 <b>56</b> , and that death occurred at <b>5:55 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. Oppler</b>		ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>10-16-56</b>					
PHYSICIAN'S NAME (Type) <b>W. OPPLER</b>		Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>10-16-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Mary</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Duda Funeral Home, 2829 Hudson St. Baltimore, Md.</b>				24a. REC'D BY REGISTRAR <b>10-22-1956</b> 24b. REGISTRAR'S SIGNATURE <b>Lene Daugherty</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10195 94

Reg. Dist. No. 181

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> <span style="float: right;"><b>10215</b></span> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Harford</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>			c. LENGTH OF STAY IN 1b <b>Enroute</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryman</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Lee</b> First <b>Arlington</b> Middle <b>Dorsey</b> Last				<b>4. DATE OF DEATH</b> Month <b>10</b> Day <b>13</b> Year <b>19 56</b>									
5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>11-7-1913</b>		9. AGE (In years last birthday) <b>42 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Auto.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Allan Arlington</b>						14. MOTHER'S MAIDEN NAME <b>Lilly J. Dorsey</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war and dates of service) <b>W.W.2</b>				16. SOCIAL SECURITY NO. <b>717-09-2457</b>		17. INFORMANT Address <b>Frances Dorsey. Perryman. Md.</b>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compound fracture of base of skull and right upper third of humerus and crushed chest. Fracture neck.</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Thrown out of car onto the road.</b>									
20c. TIME OF INJURY Hour <b>8</b> <b>10</b> <b>13</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 40</b>		20f. (City or town) <b>North East Cecil</b>		(County) <b>Md.</b>		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>R.C. Dodson</b> EXAMINER'S NAME (Type) <b>R.C. Dodson</b>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <b>10-14-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>10/18/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Aberdeen Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Barry</b>						ADDRESS <b>Aberdeen Md.</b>		24a. REC'D BY REGISTRAR DATE <b>Oct 16 - 56</b>		24b. REGISTRAR'S SIGNATURE <b>William B. Perry</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your file. Registrar place of burial, cremation, or removal.



1956 17 OCT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, as 1 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10196

10216

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>522 - 4th Street, S.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>(NMI)</b> Last <b>EVANS</b>		4. DATE OF DEATH Month <b>October</b> Day <b>8</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-25-96</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Helper</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pool Room</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Evans</b>		14. MOTHER'S MAIDEN NAME <b>Gabriel Winslow</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Empyema right pleural cavity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchopneumonia bilateral unresolved</b> DUE TO (c) <b>Arteriosclerotic brain disease with right sided hemiplegia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>7 days</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, general, severe (unknown)</b>		19. WAS AUTOPSY PERFORMED? <b>Yes</b> <input checked="" type="checkbox"/> <b>No</b> <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. <b>VA</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 21</b> , 1954, to <b>October 8</b> , 1956, and that death occurred at <b>11:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. Oppler</b>		ADDRESS (Street, city or town, state) <b>Director, Professional Services</b>	
PHYSICIAN'S NAME (Type) <b>W. OPPLER</b>		DATE SIGNED <b>10-9-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>10-9-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington</b>		ADDRESS <b>St. Anne de Grace, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>10-10-56</b>		24b. REGISTRAR'S SIGNATURE <b>Ernest E. Dougherty</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10197

CERTIFICATE OF DEATH

Reg. Dist. No. 96

10217

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Bucks</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Black Eddy</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>75x 3</b>	
3. NAME OF DECEASED (Type or print) First <b>EARLE</b> Middle <b>H.</b> Last <b>FREEMAN</b>		4. DATE OF DEATH Month <b>October</b> Day <b>17</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-11-1900</b>
9. AGE (In years lost birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry J. Freeman - Deceased</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude H. Hansbury - Deceased</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction of the lungs, multiple</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Mural thrombus right ventricle</b> DUE TO (c) <b>Myocardial fibrosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b> <b>unknown</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary sclerosis severe - unknown. Arteriosclerosis, general severe - Unknown</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 8</b> , 19 <b>56</b> , to <b>October 17</b> , 19 <b>56</b> , and that death occurred at <b>9:30 a.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. Oppler</b>		ADDRESS (Street, city or town, state) <b>VAH, Perry Point, Md.</b>	
PHYSICIAN'S NAME (Type) <b>W. OPPLER</b>		DATE SIGNED <b>10-17-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>10-17-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>unknown</b>		22d. LOCATION (City, town, or county) (State) <b>unknown</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>		ADDRESS <b>Havre de Grace, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 10-17-56</b>		24b. REGISTRAR'S SIGNATURE <b>Irene E. Dougherty</b>	

9561 61 100

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10198

10203

CERTIFICATE OF DEATH

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Devine Nursing Home</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>R.</b> Last <b>GROSS</b>		4. DATE OF DEATH Month <b>October</b> Day <b>23</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>May 19, 1867</b>
9. AGE (In years last birthday) yrs. <b>89</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>never employed</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas B. Gross</b>		14. MOTHER'S MAIDEN NAME (Last) <b>Elizabeth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Joseph L. Thompson, R. D. Elkton, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Tumor of the rectum - type unknown</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 19</b> , 19 <b>54</b> , to <b>Oct. 23</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Oct. 22</b> , 19 <b>56</b> , and that death occurred at <b>8:15 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>233 E. Main St., Elkton, Md.</b> DATE SIGNED <b>10/23/56</b>			
ACTUAL SIGNATURE <b>S. Ralph Andrews, Jr.</b>		M.D. <b>233 E. Main St., Elkton, Md.</b>	
PHYSICIAN'S NAME (Type) <b>S. Ralph Andrews, Jr., M.D. 233 East Main St., Elkton, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 27, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Union Meth. Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cecil, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Reph E. Hicks</b>		ADDRESS <b>103 Stockton St., Elkton</b>	
24a. REC'D BY REGISTRAR <b>10/25/56</b>		24b. REGISTRAR'S SIGNATURE <b>FR Trager</b>	



CERTIFICATE OF DEATH

10213

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		Male		38		1918		BALTIMORE, MARYLAND	
MARRIAGE		SINGLE		MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE	
None		None		None		None		None	
OCCUPATION		PROFESSION		EDUCATION		RELIGION		CAUSE OF DEATH	
None		None		None		None		None	
DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF REGISTRAR	
1956		BALTIMORE, MARYLAND		None		None		None	

BUREAU V. S.

OCT 30 1956

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10200

10218

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>1 month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Conowingo</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>E.</b> Last <b>HENDERSON</b>				4. DATE OF DEATH Month <b>October</b> Day <b>20</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1891</b>		9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Conowingo, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Amos Henderson</b>				14. MOTHER'S MAIDEN NAME <b>Blanche Hall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Hospital records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Edema, pulmonary, bilateral, severe</b> <b>570.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Azotemia (clinical)</b> DUE TO (c) <b>Volvulus small bowel</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3-4 hours</b> <b>4-5 days</b> <b>4-5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral edema, moderate</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF DEATH Hour a. p. m. <b>VA</b> Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 20</b> , 19 <b>56</b> , to <b>October 20</b> , 19 <b>56</b> , and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. Oppler</b>		ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>10-22-56</b>					
PHYSICIAN'S NAME (Type) <b>W. OPPLER</b>		Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>10-21-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zear</b>		22d. LOCATION (City, town, or county) (State) <b>Conowingo, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernington &amp; Son</b>				ADDRESS <b>de Grace, Md</b>		24a. REC'D BY REGISTRAR DATE <b>10-22-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Irene E. Doughty</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HENDERSON		Male		45		1911		Baltimore		Maryland		United States			
MARRIAGE		SINGLE		MARRIED		DATE		PLACE		CITY		STATE		COUNTRY	
Never married															
EDUCATION		SCHOOLING		HIGHER SCHOOLING		DATE		PLACE		CITY		STATE		COUNTRY	
High School Graduate		Graduated		Graduated		1930		Baltimore		Maryland		United States			
OCCUPATION		INDUSTRY		VOCATION		DATE		PLACE		CITY		STATE		COUNTRY	
Police Officer		Police Department		Police Department		1935		Baltimore		Maryland		United States			
CAUSE OF DEATH		IMMEDIATE		INTERMEDIATE		DATE		PLACE		CITY		STATE		COUNTRY	
Heart Disease		Coronary Artery Disease		Coronary Artery Disease		1956		Baltimore		Maryland		United States			
MANNER OF DEATH		NATURAL		ACCIDENT		DATE		PLACE		CITY		STATE		COUNTRY	
Natural															
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		STATE		CITY		STATE		COUNTRY	
J. H. Henderson		10/23/56		Baltimore		Maryland		United States							
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		STATE		CITY		STATE		COUNTRY	
J. H. Henderson		10/23/56		Baltimore		Maryland		United States							

BUREAU A. 1

OCT 23 1956

RECEIVED

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jacob</b> Middle <b>W.</b> Last <b>Hevlow</b>			4. DATE OF DEATH Month <b>October</b> Day <b>10</b> Year <b>1956</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1900</b>		9. AGE (In years lost birthday) <b>56</b> yrs.	IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Government</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chauffeur</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Reuben Hevlow</b>				14. MOTHER'S MAIDEN NAME <b>Annie Metz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Anna L. Campbell</b>		Address <b>Chesapeake City Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>541.0 Duodenal Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Duodenal Ulcer</b> DUE TO (c) <b>2 year</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct. 8, 1956</b> to <b>Oct. 9, 1956</b> , that I last saw the deceased alive on <b>Oct 9</b> 19 <b>56</b> , and that death occurred at <b>3:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Henry Davis MD</b>			ADDRESS (Street, city or town, state) <b>Chesapeake City, Md.</b>			DATE SIGNED <b>10/11/56</b>	
PHYSICIAN'S NAME (Type) <b>HENRY V. DAVIS MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/13/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>near Chesapeake City, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Henry Pippin</b>				ADDRESS <b>Elkton Md.</b>		24a. REC'D BY REGISTRAR DATE <b>10/13/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>JR. Frazier</b>			

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CITY	
STATE		COUNTY	
DECEASED'S NAME		SEX	
AGE		MARRIED	
OCCUPATION		EDUCATION	
CAUSE OF DEATH		MANNER OF DEATH	
DATE OF BURIAL		PLACE OF BURIAL	
NAME OF FUNERAL HOME		NAME OF MINISTER	
NAME OF WITNESSES		NAME OF REGISTRAR	
SIGNATURE OF REGISTRAR		DATE	

BUREAU V. S.

OCT 16 1956

RECEIVED

10219

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PERRY POINT</b>		c. LENGTH OF STAY IN 1b <b>14 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
		d. STREET ADDRESS <b>2018 Gough Street</b>	
3. NAME OF DECEASED (Type or print) First <b>MARTIN</b> Middle <b>JAKUB</b> Last <b>CZAK</b>		4. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 13, 1898</b>
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Presser</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cleaning Establishment</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE GRSINA</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES ROCMKI</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <input checked="" type="checkbox"/> <b>WW-I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records, VAH., Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Liver</b> <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>Sept. 19</b> , 19 <b>56</b> , to <b>Oct. 3</b> , 19 <b>56</b> , and that death occurred at <b>8:13A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Perry Point, Md.</b> DATE SIGNED <b>10-4-56</b>			
ACTUAL SIGNATURE <b>W. Oppler</b>		M.D. _____	
PHYSICIAN'S NAME (Type) <b>W. OPPLER, M. D., Director, Professional Services, VAH., Perry Point, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	22b. DATE THEREOF <b>10-4-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. S. PAIKOWSKI, Undertaker, Baltimore, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>Oct. 4, 1956</b>	
		24b. REGISTRAR'S SIGNATURE <b>June E. Banghart</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, as 1 and 2, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your file. If burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10205

10203

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Maryland	
c. LENGTH OF STAY IN 1b 11 hours		d. STREET ADDRESS 107 College Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Jones		4. DATE OF DEATH 10 Month 30 Day Year 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/13/1891
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Shoe Hospital	
11. BIRTHPLACE (State or foreign country) Cherry Hill, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Otis Jones		14. MOTHER'S MAIDEN NAME Cora Holland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-03-0817	
17. INFORMANT Miss Fannie Simpers, Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10/30/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-2-56	
22c. NAME OF CEMETERY OR CREMATORY Providence Cemetery		22d. LOCATION (City, town, or county) (State) ELKTON, Cecil Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Otis J. Bullock		ADDRESS 556 Lenox St. Harre de Harre, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE J. R. Frazer	
DATE Nov 1 '56			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

NOV 5 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. The funeral director is to be given a copy of this certificate. The funeral director is to be given a copy of this certificate. The funeral director is to be given a copy of this certificate.

VS. A15ME(5)  
5M 9/55 ✓

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10220

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle S. Last JONES		4. DATE OF DEATH Month October Day 24 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-1-81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (Masonic Rep.)		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Glenn T. Jones		14. MOTHER'S MAIDEN NAME (Unknown) Fletcher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost, (c)		INTERVAL BETWEEN ONSET AND DEATH immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. D. DODSON		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. D. DODSON		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-27-56	
22c. NAME OF CEMETERY OR CREMATORY Glennwood Cemetery		22d. LOCATION (City, town, or county) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co		ADDRESS 2901-14th St. N.W.	
24a. REC'D BY REGISTRAR DATE 10-24-56		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

BUREAU V. S.

OCT 26 1956

RECEIVED

10221

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PERRY POINT, MD.</b>				c. LENGTH OF STAY IN 1b <b>3 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>36 S. CATHERINE STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JULIAN</b> Middle <b>J.</b> Last <b>KING</b>			4. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>1956</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-30-12</b>		9. AGE (In years last birthday) <b>44</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>JAMES E. KING</b>			14. MOTHER'S MAIDEN NAME <b>CORA DAYMUTHE</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <input checked="" type="checkbox"/> <b>WWII</b> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>212-14-5254</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary sclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b> Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept. 20</b> , 19 <b>56</b> , to <b>Oct. 5</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Oct. 5, 1956</b> , and that death occurred at <b>6:07A.M.</b> , from the causes on and the date stated above. ADDRESS (Street, city or town, state) <b>Perry Point, Md.</b> DATE SIGNED <b>10-5-56</b> ACTUAL SIGNATURE <b>W. Oppler</b> M.D. PHYSICIAN'S NAME (Type) <b>W. OPPLER, M.D., Director, Professional Services, VAH, Perry Point, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>10-5-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. ELDERLY DIRECTOR'S SIGNATURE <b>TURMAN SCHWAD, Undertaker, Baltimore, MD.</b>				24a. REC'D BY REGISTRAR DATE <b>10 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Frederick Schuchter</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director must sign it. This certificate must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
OCT 10 1956  
BUREAU V. S.

OCT 10 1956



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the 3 short forms should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10206

10222

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>1234 Massachusetts Ave., N.W.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>H.</b> Last <b>KIRK JR.</b>		4. DATE OF DEATH Month <b>October</b> Day <b>14</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8-31-12</b>
9. AGE (In years lost birthday) <b>44</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bar Tender</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES H. KIRK</b>		14. MOTHER'S MAIDEN NAME <b>MARY MOORE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>199 01 7250</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis acute, due to extravasated contents</b> <b>576 x</b> DUE TO <b>of visceral (post-operative)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary edema and congestion, bilateral</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>36-48 hours</b> <b>24 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, moderate (unknown)</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 26, 1956</b> , to <b>October 14, 1956</b> , and that death occurred at <b>7:15 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, Perry Point, Md.</b> DATE SIGNED <b>10-15-56</b>			
ACTUAL SIGNATURE <b>W. Oppler</b>		M.D. <b>VAH, Perry Point, Md.</b>	
PHYSICIAN'S NAME (Type) <b>W. OPPLER</b>		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>10-15-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Beverly National</b>	22d. LOCATION (City, town, or county) (State) <b>Beverly, New Jersey</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bennington &amp; Son, Hayre de Grace, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>10-15-56</b>	
		24b. REGISTRAR'S SIGNATURE <b>James E. Dougherty</b>	

BUREAU V. S.

OCT 17 1956 -

RECEIVED

**MEDICAL CERTIFICATION**

VS. A15ME(5)  
5M 9/55

STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
OCT 30 1956  
BUREAU V. &

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10208  
96

10223

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b> c. LENGTH OF STAY in 1b <b>all life</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Aiken Ave</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b> d. STREET ADDRESS <b>Aiken Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Effie</b> Middle <b>L.</b> Last <b>Nelson</b>				<b>4. DATE OF DEATH</b> Month <b>10</b> Day <b>17</b> Year <b>1956</b>													
<b>5. SEX</b> <b>F.</b>		<b>6. COLOR OR RACE</b> <b>W.</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>8-6-1862</b>		<b>9. AGE</b> (In years last birthday) <b>94</b> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																
Months	Days																
	Hours																
	Min.																
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House work</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Perryman, Md.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>U.S.A.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>									
<b>13. FATHER'S NAME</b> <b>George Michael</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Susanna Thompson</b>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b> <b>no</b>		<b>17. INFORMANT</b> <b>Mrs. Walter L. Blanchamp, Perryville, Md.</b>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> DUE TO <b>422.2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____																	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)										
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
<b>ACTUAL SIGNATURE</b> <b>R.C. Dodson</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <b>10-18-56</b>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>10/20/56</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Spesutia</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Perryman, Maryland</b>											
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John E. Farving</b>				<b>ADDRESS</b> <b>Aberdeen, Md.</b>		<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>Oct 23 1956</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Irene Dougherty</b>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your file. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by your file. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by your file. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by your file.



RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, who should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 File # G206 11-11-56 et

10224

CERTIFICATE OF DEATH

10209

Reg. Dist. No. 94

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural c. LENGTH OF STAY IN 1b 29 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Nora Rebecca Newcomb 4. DATE OF DEATH Month 10 Day 31 Year 1956											
5. SEX F. W		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-19-1875		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Washington Pryor				14. MOTHER'S MAIDEN NAME Emily Bryson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Jesse C. Ward, North East, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis with Fibrillation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10-1-56, 19, to 10-31-56, 19, that I last saw the deceased alive on 10-28-56, 19, and that death occurred at 11.45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 11-1-56 ACTUAL SIGNATURE R. C. Dodson M.D. PHYSICIAN'S NAME (Type) R. C. Dodson, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 4 1956		22c. NAME OF CEMETERY OR CREMATORY Methodist				22d. LOCATION (City, town, or county) (State) North East, Cecil, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph K. Grant North East, Maryland						24a. REC'D BY REGISTRAR DATE 11-3-56		24b. REGISTRAR'S SIGNATURE Sarah E. Rothermel			

CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]		5. PLACE OF DEATH [REDACTED]		6. TIME OF DEATH [REDACTED]	
7. CAUSE OF DEATH [REDACTED]		8. MANNER OF DEATH [REDACTED]		9. PLACE OF BIRTH [REDACTED]	
10. OCCUPATION [REDACTED]		11. MARITAL STATUS [REDACTED]		12. EDUCATION [REDACTED]	
13. PREVIOUS ILLNESS [REDACTED]		14. MEDICAL HISTORY [REDACTED]		15. TREATMENT [REDACTED]	
16. SIGNATURE OF PHYSICIAN [REDACTED]		17. SIGNATURE OF REGISTRAR [REDACTED]		18. SIGNATURE OF WITNESS [REDACTED]	
19. DATE OF SIGNATURE [REDACTED]		20. PLACE OF SIGNATURE [REDACTED]		21. SIGNATURE OF DECEASED [REDACTED]	

BUREAU V. 3

NOV 2 1956

RECEIVED

10207 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

10210

Reg. Dist. No. 92

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton		c. LENGTH OF STAY IN 1b 7 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS Cathedral St.			
3. NAME OF DECEASED (Type or print) First Regina M. Middle O'Hara Last				4. DATE OF DEATH Month OCT Day 31 Year 1956			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1902		9. AGE (In years last birthday) 54 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer		10b. KIND OF BUSINESS OR INDUSTRY Office Work		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William O'Hara				14. MOTHER'S MAIDEN NAME Mary Frazer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Marion Satterfield, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 757.1 DUE TO UREMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Polycystic Disease Kidney Bldt Congenit (c) ANEMIA Diffuse Hemorrhage GI ?						INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Old Healed Pulmonary Tuberculosis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from MAY 1955, to 31 OCT 1956, that I last saw the deceased alive on 31 OCT 1956, and that death occurred at 1:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George J. Kreis Jr.		ADDRESS (Street, city or town, state) Elkton, Md.		DATE SIGNED			
PHYSICIAN'S NAME (Type) George J. Kreis Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 3-56		22c. NAME OF CEMETERY OR CREMATORY New Catholic Cemetery		22d. LOCATION (City, town, or county) (State) R. D. Elkton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Oppie		ADDRESS 259 E. Main St Elkton, Md.		24a. REG'D BY REGISTRAR W. A. Jones		24b. REGISTRAR'S SIGNATURE H. Frazer	
DATE Nov 3 '56							

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and registrar details. The form is oriented horizontally but contains vertical text labels for various fields.

RECEIVED  
NOV 5 1956  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10211

- See: Birth Cert.

CERTIFICATE OF DEATH

Reg. Dist. No. 97

10225

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge Village</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital</u>		d. STREET ADDRESS <u>Trailer # 17</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>JAMES</u> Last <u>OLIVA</u>		4. DATE OF DEATH Month <u>10</u> Day <u>11</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-56</u>
9. AGE (In years last birthday) yrs. <u>13</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Bainbridge, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Albert OLIVA</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Lillian ADAMS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Navy Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-11</u> , 19 <u>56</u> , to <u>10-11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-11</u> , 19 <u>56</u> , and that death occurred at <u>7:20 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert J. Bise</u> M.D.		ADDRESS (Street, city or town, state) <u>U. S. NAVAL HOSPITAL</u> DATE SIGNED <u>10-12-56</u>	
PHYSICIAN'S NAME (Type) <u>ALBERT J. BISESE</u>		<u>BAINBRIDGE, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-12-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>	22d. LOCATION (City, town, or county) (State) <u>Colora, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson &amp; Son, Perryville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>10-12-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Dorothy Bramble</u>	

2051211 XV/0



RECEIVED

OCT 15 1956

BUREAU V. 3

HOSPITAL  
by be  
INTRA  
3 hr

VS A15 (4)  
15M 9/55

ENDING PHYSICIAN: The law requires that the death certificate be executed  
e hospital or attending physician.  
After this certificate has been signed by the attending physician and compl  
uched for use as the burial-transit permit. Then please remove carbon papers.

ath: Page 4

Director,  
Be filed with



10226

## CERTIFICATE OF DEATH

Reg. Dist. No.

10212

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PERRY POINT</b>		c. LENGTH OF STAY IN 1b <b>11 yrs 1mo. 8 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>A</b> Last <b>OSTRICH</b>		4. DATE OF DEATH Month <b>October</b> Day <b>26</b> Year <b>19 56</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1895</b>
9. AGE (In years last birthday) yrs. <b>61</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Naval Powder Factory</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>JOSEPH OSTRICH</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <input checked="" type="checkbox"/> <b>WW-I</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records, VAH., Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral lower lobes, unresolved.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary sclerosis, severe</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 - 4 days</b>  <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, gen. severe.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 18,</b> 19 <b>45</b> , to <b>October 26,</b> 19 <b>56</b> , and that death occurred at <b>8:45 P.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>E. S. ELLS</b> <b>M.D.</b> <b>10-27-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			
22b. DATE THEREOF <b>10-28-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
22d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Virginia.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>HUNTT &amp; RYON FUNERAL HOME, Waldorf, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>10-28-56</b>		24b. REGISTRAR'S SIGNATURE <b>James E. Dougherty</b>	

MEDICAL CERTIFICATION

Burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10282

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		M		65		JAN 15 1890		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
MARRIAGE		SINGLE		MARRIED		JAN 15 1890		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
OCCUPATION		FARMER		FARMER		JAN 15 1890		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
CAUSE OF DEATH		HEART DISEASE		HEART DISEASE		JAN 15 1890		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
MANNER OF DEATH		NATURAL		NATURAL		JAN 15 1890		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
PLACE OF DEATH		HOME		HOME		JAN 15 1890		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
DATE OF DEATH		JAN 15 1956		JAN 15 1956		JAN 15 1890		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
SIGNATURE OF DECEASED		JAMES H. HARRIS		JAMES H. HARRIS		JAN 15 1890		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
SIGNATURE OF WITNESS		JAMES H. HARRIS		JAMES H. HARRIS		JAN 15 1890		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
SIGNATURE OF PHYSICIAN		JAMES H. HARRIS		JAMES H. HARRIS		JAN 15 1890		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
SIGNATURE OF CLERK		JAMES H. HARRIS		JAMES H. HARRIS		JAN 15 1890		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	

BUREAU V. S.

OCT 30 1956

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

99

10227

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE California b. COUNTY Orange				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit			c. LENGTH OF STAY IN 1b NA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1015 S. Wood St., Fullerton 43X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1015 S. Wood Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Warren Middle Charles Last Press				4. DATE OF DEATH Month Oct Day 20 Year 1956				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-22-32		
9. AGE (In years last birthday) 24 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy			10b. KIND OF BUSINESS OR INDUSTRY Navy		11. BIRTHPLACE (State or foreign country) Rochester, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Press				14. MOTHER'S MAIDEN NAME Anita Traphagen				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. None		17. INFORMANT U. S. Naval Training Center, Bainbridge, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of the occipital bone; fracture of the Lt. knee; crushed Lt. side of chest; Mul. lacerations and abrasions of the face, head, arms and legs. DUE TO (b) None DUE TO (c) None Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							INTERVAL BETWEEN ONSET AND DEATH None	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car turned over throwing PRESS to pavement.				
20c. TIME OF INJURY Month, Day, Year 1100 p.m. 10 20 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rte 222		20f. (City or town) (County) (State) Port Deposit Cecil Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE R. C. DODSON				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) R. C. DODSON				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 10-23-56		22c. NAME OF CEMETERY OR CREMATORY Ft Rosecrans Nat. Cem.		22d. LOCATION (City, town, or county) (State) Port Loma San Diego Calif		
23. FUNERAL DIRECTOR'S SIGNATURE W. A. Patterson				ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE 10-22-56		
				24b. REGISTRAR'S SIGNATURE Dorothy B. Brinkley				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your file. File pages 1 and 2 with the registrar for removal.

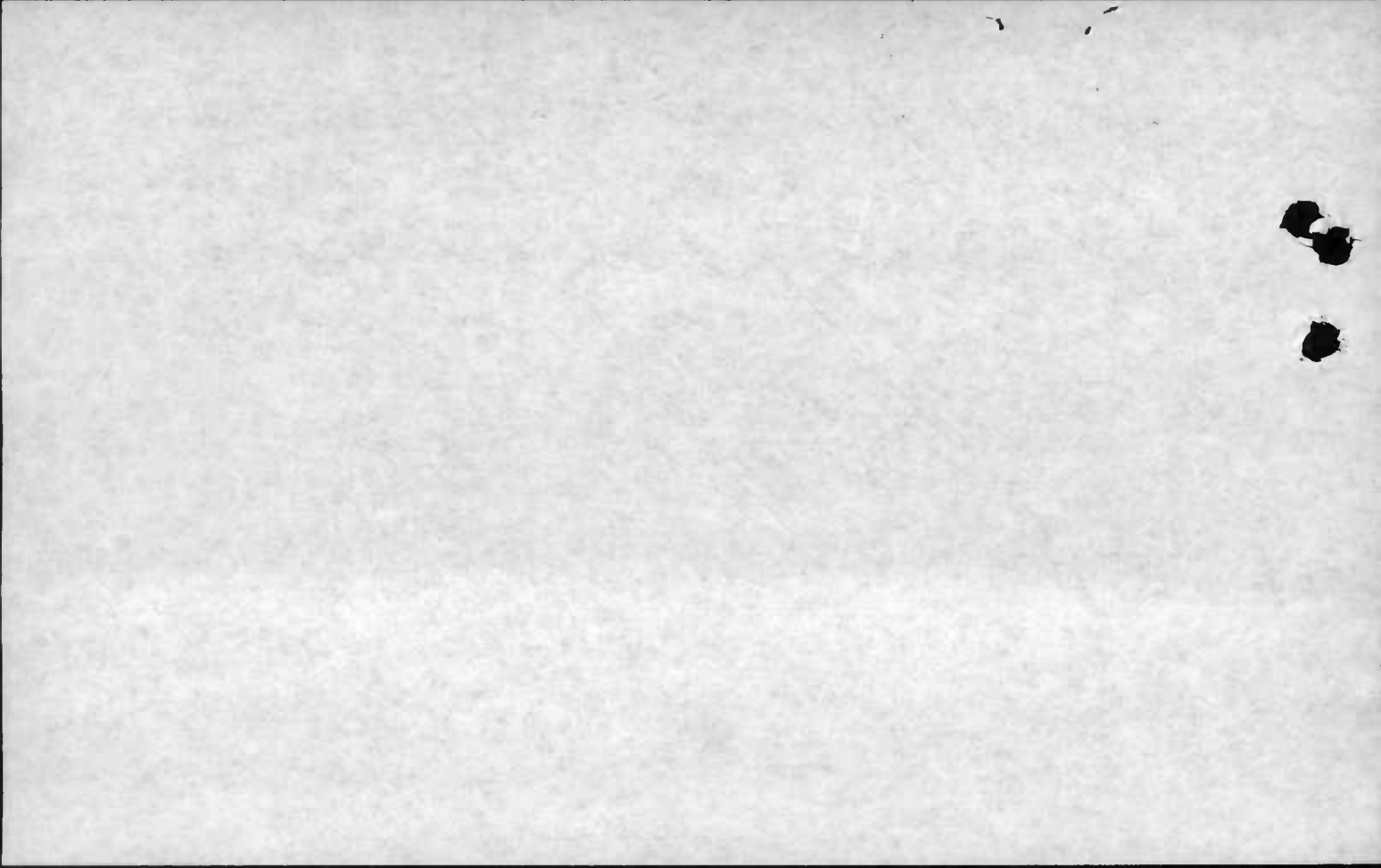
BUREAU V. S.

OCT 26 1956

RECEIVED

I will forward information  
for items 22c & 22d upon return  
of military escort from funeral.  
Net of her did not furnish  
this information.

Dorothy Bramble





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, pages 1 and 2, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10208  
CERTIFICATE OF DEATH

10214

Reg. Dist. No. 92

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charlestown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Shirley</b> Middle <b>Ann</b> Last <b>Preston</b>				4. DATE OF DEATH Month <b>October</b> Day <b>23</b> Year <b>1956</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 27, 1955</b>		9. AGE (In years lost birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>child</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Elkton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clifford Preston</b>				14. MOTHER'S MAIDEN NAME <b>Frances Gamble</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Frances Gamble Charlestown Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Undetermined</b> <b>795.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Clifton R. Brooks</b> M.D.				PHYSICIAN'S NAME (Type) <b>Clifton R. Brooks</b> <b>Newark, Del.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 27, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>North East Cecil Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Hunt North East Md</b>				24a. REC'D BY REGISTRAR DATE <b>10/26/56</b>		24b. REGISTRAR'S SIGNATURE <b>JR Fraser</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED William H. H. H.		SEX Male		DATE OF BIRTH 1901		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Clerk		MARITAL STATUS Single		COLOR White		BUILD Medium	
DATE OF DEATH October 27, 1956		TIME OF DEATH 11:15 A.M.		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS (None)		SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)		SIGNATURE OF JURY (None)		SIGNATURE OF JUDGE (None)	

BUREAU V. 2

OCT 30 1956

RECEIVED

10228

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>R.D. #1</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>P.</b> Last <b>RAAB</b>		4. DATE OF DEATH Month <b>October</b> Day <b>1</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-5-92</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter Raab</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Brockmeyer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary sclerosis, severe</b> <b>545X</b> DUE TO <b>Cardiac arrhythmia ventricular, interventricular septal infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hemorrhage marginal ulcer gastrojejunostomy</b> (c) <b>Partial gastric resection for marginal ulcer</b> INTERVAL BETWEEN ONSET AND DEATH <b>3-5 days</b> <b>7-10 days</b> <b>6 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, general, severe (unknown)</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> 19 <b>56</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 29</b> , 19 <b>56</b> , to <b>October 1</b> , 19 <b>56</b> , and that death occurred at <b>10:17 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, Perry Point, Md.</b> DATE SIGNED <b>10-2-56</b> ACTUAL SIGNATURE <b>W. Oppler</b> M.D. PHYSICIAN'S NAME (Type) <b>W. OPPLER</b> Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>10-2-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home</b>		24a. REC'D BY REGISTRAR <b>OCT 9 1956</b>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0278

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
John Doe		Male		45		1910		Maryland		Baltimore		Maryland		United States	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Teacher		Heart Disease		Natural		1955		Baltimore		Maryland		Maryland		United States	
FAMILY HISTORY		PREVIOUS ILLNESS		TREATMENT		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
None		None		None		1955		Baltimore		Maryland		Maryland		United States	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
[Signature]		[Signature]		[Signature]		1955		Baltimore		Maryland		Maryland		United States	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
1955		Baltimore		Maryland		Maryland		United States		Baltimore		Maryland		United States	

RECEIVED  
OCT 9 1956  
BUREAU A. 2

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. A bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10216

## 10209 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Cecil</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> TOWN STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Arthur Miller Ross</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>Oct 23 - 1956</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec 10-1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>55</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Cecil County Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>William Henry Ross</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT'S ADDRESS <u>Mrs John E. Lewis - sister</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 3221 IMMEDIATE CAUSE (A) <u>Cardio-Vascular renal disease</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>General arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Alcoholism</u> about <u>33 yrs</u>		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>unknown</u> <u>33 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>Oct 18 1956 Oct 23 1956</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 23 1956</u> to <u>Oct 23 1956</u> , that I last saw the deceased alive on <u>Oct 23 1956</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>A. M. Smith</u> M.D. ADDRESS <u>Elkton, Maryland</u> DATE SIGNED <u>Oct 23 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 26, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Cemetery</u>		LOCATION (City, town or county) (State) <u>Cecil, Maryland</u>	
24. REC'D BY REGISTRAR <u>10/25/56</u>		REGISTRAR'S SIGNATURE <u>JR Frazer</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		ADDRESS <u>103. Stockton St. Elkton</u>	



# 10500 CERTIFICATE OF DEATH

Page Two, 11a

TO BE FILLED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH

TO BE FILLED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH

NAME OF DECEASED  
 SEX  
 AGE  
 DATE OF BIRTH  
 PLACE OF BIRTH  
 OCCUPATION  
 MARITAL STATUS  
 COLOR  
 RELIGION  
 EDUCATION  
 SOCIAL CLASS  
 RACE  
 ETHNIC ORIGIN  
 PLACE OF DEATH  
 DATE OF DEATH  
 TIME OF DEATH  
 CAUSE OF DEATH  
 MANNER OF DEATH  
 PLACE OF BURIAL  
 DATE OF BURIAL  
 TIME OF BURIAL  
 NAME OF BURIAL PLACE  
 NAME OF BURIAL OFFICER  
 NAME OF BURIAL OFFICER'S FIRM  
 NAME OF BURIAL OFFICER'S ADDRESS  
 NAME OF BURIAL OFFICER'S PHONE NUMBER  
 NAME OF BURIAL OFFICER'S CITY  
 NAME OF BURIAL OFFICER'S STATE  
 NAME OF BURIAL OFFICER'S ZIP CODE

NAME OF PHYSICIAN  
 ADDRESS  
 CITY  
 STATE  
 ZIP CODE  
 NAME OF PHYSICIAN'S FIRM  
 ADDRESS  
 CITY  
 STATE  
 ZIP CODE  
 NAME OF PHYSICIAN'S PHONE NUMBER  
 NAME OF PHYSICIAN'S CITY  
 NAME OF PHYSICIAN'S STATE  
 NAME OF PHYSICIAN'S ZIP CODE

NAME OF PHYSICIAN  
 ADDRESS  
 CITY  
 STATE  
 ZIP CODE  
 NAME OF PHYSICIAN'S FIRM  
 ADDRESS  
 CITY  
 STATE  
 ZIP CODE  
 NAME OF PHYSICIAN'S PHONE NUMBER  
 NAME OF PHYSICIAN'S CITY  
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 NAME OF PHYSICIAN'S ZIP CODE

NAME OF PHYSICIAN  
 ADDRESS  
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 NAME OF PHYSICIAN'S FIRM  
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 NAME OF PHYSICIAN'S PHONE NUMBER  
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 NAME OF PHYSICIAN'S STATE  
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 NAME OF PHYSICIAN'S PHONE NUMBER  
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NAME OF PHYSICIAN  
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 ZIP CODE  
 NAME OF PHYSICIAN'S FIRM  
 ADDRESS  
 CITY  
 STATE  
 ZIP CODE  
 NAME OF PHYSICIAN'S PHONE NUMBER  
 NAME OF PHYSICIAN'S CITY  
 NAME OF PHYSICIAN'S STATE  
 NAME OF PHYSICIAN'S ZIP CODE

BUREAU V. S.

OCT 30 1956

RECEIVED

RECEIVED  
 OCT 30 1956  
 BUREAU V. S.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. The registrar must be present at burial, cremation, or removal. File pages 1 and 2 with the registrar permit. File pages 3 and 4 with the registrar permit.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10217

Reg. Dist. No. 97

10229

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Suffolk			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge		c. LENGTH OF STAY IN 1b 36 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lake Ronkonkoma		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS West 4th & Laurel Blvd			
3. NAME OF DECEASED (Type or print) First Middle Last HAROLD KIRBY SPALDING				4. DATE OF DEATH Month Day Year 10 22 19 56			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-9-30	
9. AGE (In years last birthday) 26 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME KIRBY HOLMES SPALDING				14. MOTHER'S MAIDEN NAME MARION OSWALL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> Korea		16. SOCIAL SECURITY NO. 128 22 3207		17. INFORMANT KIRBY H. SPALDING (Brother same as Item 2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURE CERVICAL SPINE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 36 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car turned over man thrown out of car					
20c. TIME OF INJURY Month, Day, Year Hour <del>AM</del> p. m. 10 20 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 222		20f. (City or town) (County) (State) Port Deposit Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. DODSON				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. DODSON				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10-23-56		22c. NAME OF CEMETERY OR CREMATORY L.I. NATIONAL		22d. LOCATION (City, town, or county) (State) Farmingdale, Suffolk, N. Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, Parrisville, Md.				24a. REC'D BY REGISTRAR DATE 10-23-56		24b. REGISTRAR'S SIGNATURE Dorothy B. Bumble	

MEDICAL CERTIFICATION

MARY AND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

OCT 26 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. A bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10230 CERTIFICATE OF DEATH

10218

Reg. Dist. No. 91

1. PLACE OF DEATH COUNTY Cecil MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chesapeake City HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Cecil CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chesapeake City STREET ADDRESS (If rural give location) Canal Street			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Alice Bertha Warner				4. DATE OF DEATH (Month) (Day) (Year) Oct. 9 1956 19			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Jan. 13, 1876	9. AGE last birthday 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard W. Reynolds				14. MOTHER'S MAIDEN NAME Martha J. Donahue			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs. Hilda W. Berger, Chesapeake City			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A) Pulmonary Edema				INTERVAL BETWEEN ONSET AND DEATH 2 days			
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral hemorrhage				2 mos			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Cardiac vascular, renal				3 years			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8/13, 1956, to 10/9, 1956, that I last saw the deceased alive on 10/8, 1956, and that death occurred at 6:00 P.M. from the causes and on the date stated above.							
SIGNATURE J. Herbert Bates				DATE SIGNED 10/11/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 12, 1956		NAME OF CEMETERY OR CREMATORY St. Augustine Cemetery		LOCATION (City, town, or county) (State) Chesapeake City (Rural) Md.	
24. REC'D BY REGISTRAR DATE Oct 12-1956		REGISTRAR'S SIGNATURE MRS. L. P. H. H. R. R.		25. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS North East Md.	

# CERTIFICATE OF DEATH

Form No. 1

1. DEATH OF NATURAL PERSONS OR BEINGS

2. DEATH OF ARTIFICIAL PERSONS OR BEINGS

3. DEATH OF ARTIFICIAL PERSONS OR BEINGS

4. DEATH OF ARTIFICIAL PERSONS OR BEINGS

5. DEATH OF ARTIFICIAL PERSONS OR BEINGS

6. DEATH OF ARTIFICIAL PERSONS OR BEINGS

7. DEATH OF ARTIFICIAL PERSONS OR BEINGS

8. DEATH OF ARTIFICIAL PERSONS OR BEINGS

9. DEATH OF ARTIFICIAL PERSONS OR BEINGS

10. DEATH OF ARTIFICIAL PERSONS OR BEINGS

11. DEATH OF ARTIFICIAL PERSONS OR BEINGS

12. DEATH OF ARTIFICIAL PERSONS OR BEINGS

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BUREAU V. S.

OCT 15 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10219

10231

## CERTIFICATE OF DEATH

Reg. Dist. No.

94

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CECIL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NORTH EAST</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NORTH EAST RURAL</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RURAL</b>				d. STREET ADDRESS <b>RURAL</b>			
3. NAME OF DECEASED (Type or print) First <b>E S A</b> Middle <b>-</b> Last <b>WESTERINEN</b>				4. DATE OF DEATH Month <b>10</b> Day <b>29</b> Year <b>19 56</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-10-1884</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		11. BIRTHPLACE (State or foreign country) <b>FINLAND</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (State or foreign country) <b>FINLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>E S A WESTERINEN</b>				14. MOTHER'S MAIDEN NAME <b>CHRISTINE HAMALAINEN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>218-12-833A</b>			
17. INFORMANT <b>Jenni Westerinen North East, Md</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart and circulatory failure</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bilateral lobar pneumonia</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, status post hemiplegia</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>10-27</b> , <b>56</b> , to <b>10-29</b> , <b>56</b> , that I last saw the deceased alive on <b>10-28-56</b> , <b>19</b> , and that death occurred at <b>8:15</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Otto Vogel, M.D.</b>				ADDRESS (Street, city or town, state) <b>10-29-56</b>			
DATE SIGNED				DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>OTTO VOGEL, M.D.</b>				NORTH EAST, Md, Cecil Ave			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 1 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>North East Cecil Ave</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant North East Md</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>DATE 10-31-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Sarah E. Rothermel</b>							



STATIONERIES, 1900-1901

BUREAU V. 3.

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